APPROVED

BOARD OF DENTISTRY

MINUTES
FORMAL HEARING

TIME AND PLACE: A meeting of the Virginia Board of Dentistry convened on August 17, 2007, at 9:12 a.m., at the Holiday Inn Crossroads I-64, 2000 Staples Mill Road, Richmond, Virginia.

PRESIDING: Paul N. Zimmet, D.D.S.

MEMBERS PRESENT:
Meera A. Gokli, D.D.S.
Myra Howard
Jeffrey Levin, D.D.S.
Jacqueline G. Pace, R.D.H.
Darryl J. Pirok, D.D.S.
Edward P. Snyder, D.D.S.
James D. Watkins, D.D.S.
Glenn A. Young, D.D.S.

MEMBERS ABSENT: Misty L. Sissom, R.D.H.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Alan Heaberlin, Deputy Director
Cheri Emma-Leigh, Operations Manager
Gail W. Ross, Adjudication Specialist

COUNSEL PRESENT: Howard Casway, Senior Assistant Attorney General

OTHERS PRESENT:
James Schliessmann, Assistant Attorney General
Andrea Pegram, Court Reporter, Crane-Snead and Associates

QUORUM: With nine members present, a quorum was established.

RICHARD R. HULL, D.M.D.
Case Nos. 111322, 107156, 108380 and 108618

Richard R. Hull, D.M.D. appeared with counsel, Walter Peake, Esq., Donna Foster, Esq., and Rodney Adams, Esq. to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that

1. In or about 2005 and 2006, outside a bona fide dentist-patient relationship and without an accepted medicinal or therapeutic purpose, he dispensed/sold at least 900 dosage units of Vicoprofen, a Schedule III controlled substance, to Individual A. Said dispensing/selling was done to accommodate a presecription authorized by an

out-of-state-practitioner and was in exchange for labor performed by Individual A for Dr. Hull.

2a. In or about March 2005, he provided ill-fitting dentures to Individual A that subsequently broke, cutting his mouth.

2b. On or about September 8, 2005, he extracted Patient B's teeth #2, #15, #18, and #31, rather than teeth #1, #16, #17, and #32, for which treatment was indicated. Subsequently, Patient B required additional surgery by another dentist to remove a bone fragment that was protruding from the gum.

2c. In or about July 2004, Dr. Hull provided Patient C with ill-fitting dentures that would not stay in his mouth.

3. Pursuant to a Board Order entered June 2, 2005, an unannounced inspection of his practice was conducted on May 17, 2006, by an investigator of the Department of Health Professions and the following deficiencies were noted:

   a. Dr. Hull administered conscious sedation and he failed to have the following required emergency airway equipment in the office: oral and nasopharyngeal airways, endotracheal airways with connectors and laryngoscope with reserve batteries, pulse oximetry, blood pressure monitoring equipment readily accessible to the patient service area, pharmacologic antagonist agents, and appropriate emergency drugs for patient resuscitation.
   b. Radiation certificates for persons who place or expose dental x-ray film were not posted in plain view of the patient.
   c. Expired medications were maintained within the working stock in his office.
   d. Dr. Hull failed to take a complete and accurate initial inventory of all stocks of Schedule II-V drugs.
   e. Dr. Hull failed to maintain a biennial inventory of Schedule II-V drugs.
   f. The record of drugs received failed to show

the date of receipt.

g. Dr. Hull failed to include a record of all drugs administered or dispensed, including dates the drugs were administered or dispensed and names of the persons receiving the drug.
h. Dr. Hull failed to maintain a complete and accurate record of drugs for a period of two years from the date of the aforementioned transactions.

The Board admitted into evidence Commonwealth's exhibits 1 through 8. Ms. Foster objected to Commonwealth's exhibit no. 2 regarding the Consent Order that was entered June 2, 2005. The objection was over-ruled by Dr. Zimmet. Mr. Peake objected to Commonwealth's exhibit no. 7 regarding a written statement from Individual A attesting that all statements made to the Investigator, Carole Crutchfield, were true. The objection was over-ruled by Dr. Zimmet.

The Board admitted into evidence Respondent's exhibits A through C.

Dr. Hull testified on his own behalf. Testifying on behalf of the Respondent were Thomas Edwards and Kathy Parks.

Testifying on behalf of the Commonwealth were Carole Crutchfield, Investigator, and Sandra Carson.

Closed Meeting: Dr. Snyder moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Richard R. Hull. Additionally, Dr. Snyder moved that Board Counsel, Howard Casway, Board staff, Sandra Reen, Alan Heaberlin, and Cheri Emma-Leigh, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Snyder moved to certify that only matters lawfully exempted from open meeting requirements under Virginia

law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Mr. Casway read the Findings of Facts as adopted by the Board as follows:

1. Dr. Hull was issued a license to practice dentistry on November 17, 1980.
2. By Order entered May 15, 2007, Dr. Hull's license to practice dentistry in the Commonwealth of Virginia was summarily suspended.
3. Dr. Hull violated §§ 54.1-2706 (5), (11), (12) and (15) of the Code, in that, in or about 2005 and 2006, outside a bona fide dentist-patient relationship and without an accepted medicinal or therapeutic purpose, he dispensed/bartered at least 1200 dosage units of Vicoprofen, a Schedule III controlled substance, to Individual A.
    a. By Dr. Hull's own admission, he dispensed Vicoprofen ostensibly to relieve generalized complaints of osteoarthritis, which was unrelated to any dental treatment, based on a purported prescription of an out-of-state-practitioner to accommodate Individual A.
    b. Dr. Hull stated to the Board's investigator on March 14, 2007, that he traded the drug, Vicoprofen, in exchange for labor performed by Individual A.
    c. Dr. Hull stated that a majority of his 2005 and 2006 purchases of Vicoprofen from Sullivan-Schein Dental were for Individual A, and submitted copies of invoices to indicate purchase dates.
    d. Dr. Hull provided to the investigator a signed handwritten statement, dated November 2, 2006, which he claimed to have presented in a court proceeding. This document outlined the arrangements Dr. Hull made with

Individual A for dental work and receipt of the Vicoprofen. Specifically, Dr. Hull stated that he dispensed 300 tablets of Vicoprofen to Individual A, from Sullivan Schein Dental, at a purchase price of six hundred eighty-one dollars and forty-four cents ($681.44) per purchase on four different occasions over a 21 month period totaling 1200 dosage units.

4. Dr. Hull violated §§ 54.1-2706(5) and (11) of the Code, in that, upon referral by another dentist, Patient B, a 17 year old sought treatment from Dr. Hull for extraction of her wisdom teeth as originally requested by the patient's mother and as directed by her orthodontist and primary dentist. On or about September 8, 2005, without consulting with the primary dentist and/or the orthodontist, without documentation of the existence of the appropriate evidence to support his clinical decision and without written documentation of an informed consent, Dr. Hull extracted Patient B's teeth #2, #15, #18, and #31, rather than teeth #1, #16, #17, and #32, for which treatment was indicated.
5. A treatment record dated September 20, 2005, for Patient B from an orthodontist noted that Patient B's retainer no longer fit. A clinical examination revealed fresh extraction sites of the 12-year molars. The orthodontist concluded that extraction of the 12-year molars was not usually done and absolutely contrary to what was agreed to by the orthodontist and the primary dentist, resulting in the need for future orthodontic treatment.
6. Pursuant to a Board Order entered June 2, 2005, an unannounced inspection of Dr. Hull's practice was conducted on May 17, 2006, by an investigator of the Department of Health Professions. The following deficiencies were noted:

a. Dr. Hull violated § 54.1-2706(9) of the Code and 18 VAC 60-20-120.E(2), (3), (4), (5), (6) and (9) of the Regulations, in that, he failed to have the following required emergency airway equipment in the office where he administers conscious sedation: oral and nasopharyngeal

airways, endotracheal airways with connectors and laryngoscope with reserve batteries, pulse oximetry, blood pressure monitoring equipment readily accessible to the patient service area, pharmacologic antagonist agents, and appropriate emergency drugs for patient resuscitation.

b. Dr. Hull violated § 54.1-2706(9) of the Code and 18 VAC 60-20-195 of the Regulations, in that, the radiation certificates for persons who place or expose dental x-ray film were not posted in plain view of patients.

c. Dr. Hull violated §§ 54.1-2706(5) and (11) of the Code, in that, expired medications were maintained within the working stock in his office.

d. Dr. Hull violated §§ 54.1-2706(11) and 54.1-3404.A of the Code, in that, he failed to take a complete and accurate initial inventory of all stocks of Schedule II-V drugs.

e. Dr. Hull violated §§ 54.1-2706(11) and 54.1-3404.B of the Code, in that, he failed to maintain a biennial inventory of Schedule II-V drugs.

f. Dr. Hull violated §§ 54.1-2706(11) and 54.1-3404.C of the Code, in that, the record of drugs received failed to show the date of receipt.

g. Dr. Hull violated §§ 54.1-2706(11) and 54.1-3404.D of the Code, in that, he failed to include a record of all drugs administered or dispensed, including dates the drugs were administered or dispensed and names of the persons receiving the drug.

h. Dr. Hull violated §§ 54.1-2706(11) and 54.1-3404.F of the Code, in that, he failed to maintain a complete and accurate record of drugs for a period of two years from the date of the aforementioned transactions. Dr. Hull, moreover, failed to account for the disposal/destruction of his controlled substances inventory. Dr. Hull providedthe

department investigator with documents that ostensibly detailed the disposal of the controlled substances at Stonewall Jackson Hospital and the Rockbridge Area Free Clinic. Further investigation revealed there had been no disposal/donation at the foregoing facilities. Dr. Hull claimed he had given them to an unnamed hospital pharmacy technician who purportedly stored them in a hospital maintenance closet. Dr. Hull testified that after nine (9) months, following his discussion with the investigator, he went to the hospital and removed the drugs, returning them to his office until he could dispose of them properly. The drugs in stock on May 17, 2006 and the drugs allegedly taken to the hospital in comparison with Respondent's Exhibit B, revealed significant discrepancies in quantities.

7. On May 19, 2006, Dr. Hull indicated to the investigator that he would cease administering nitrous oxide in his office if pulse oximetry was required. In order to comply with the Board's regulations, Dr. Hull ordered drugs for patient resuscitation and emergency airway equipment, as cited in 3a. He did not order pulse oximetry.
8. On May 31, 2006, Dr. Hull provided to the investigator an invoice from Sullivan-Schein Dental that showed patient resuscitation and emergency airway equipment was received in his office.

The sanctions reported by Mr. Casway were that Dr. Hull be continued on suspension until May 15, 2008, at which time he will be reinstated administratively on stayed suspension upon the following terms and conditions:

1. Provide proof of the surrender of his DEA license.
2. Be assessed a monetary penalty of $26,000.
3. Be required to complete seven (7) continuing education hours in ethics, four (4) continuing education hours in recordkeeping, seven (7) continuing education hours in risk management, and seven (7) continuing education hours in diagnosis and treatment planning.

4. Be required to take the Board's dental law examination.

Dr. Pirok moved to adopt the Findings of Fact, Conclusions of Law, and the sanctions as read by Mr. Casway and issuing an Order stating such. The motion was seconded and passed.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of the Board.

ADJOURNMENT: With all business concluded, the Committee adjourned at 5:15 p.m.

Paul N. Zimmet, D.D.S., Chair	Sandra K. Reen, Executive Director
Date	Date